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ABSTRACT

The prevention planning process pursued within the National Institute of Mental Health in 1978 is described and related to federal proposals on primary prevention program planning in the mental health field. The conceptual frameworks and parameters of prevention planning are cited, along with the specific new prevention initiatives to be emphasized. Policy and program considerations, as well as the recommendations on prevention contained in the Report of the President's Commission on Mental Health, are discussed. (Author)

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EMERGING PRIMARY PREVENTION PROGRAMS: 1978

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INTRODUCTION

Precisely one year ago today at our Annual Meeting in San Francisco I presented a paper entitled "Primary Prevention Programming from the Federal Perspective: Status and Trends - 1977". Several concepts offered on that occasion have remained relevant over the months and have served as the text of my exhortations at numerous meetings across the land during the past year. In summary, these concepts are three in number:

(1) Primary prevention is an idea whose time has come. We stand at the threshhold of a long over-due national emphasis and initiative in primary prevention.

(2) A "critical mass" of information related to primary prevention has been compiled including sufficient research to provide a solid knowledge base for program development.

(3) Although prevention is "in" politically, the commitment of the mental health field (at all levels) remains uncertain at best.

The events of the past year reinforce these perspectives. Within the context of these concepts, this paper presents (1) a brief status report about what has transpired at the Federal level with respect to primary prevention over the past year, (2) current issues, and (3) some thoughts about key matters requiring resolution over the coming months.

STATUS REPORT

The Planning Process

Prevention has been a major concern within the U.S. Public Health Service over the past nine months. An intensive planning effort began last December

within PHS, directed from the Office of the Assistant Secretary for Health/Surgeon General. At the outset, the conceptual base for prevention planning was derived from the Lalonde Report prepared by the former Canadian Minister of National Health and Welfare (Lalonde, 1974). The following statement presents the fundamental position expounded in that document:

> "Marvelous though health care services are in Canada in comparison with many other countries, there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology."

In addition, this Report introduced the Health Field Concept which consists of four broad elements: human biology, environment, lifestyle, and health care organization. Prevention planning in the PHS utilized two of the elements as formulated (lifestyle and environment), and modified the third (from health care organization to personal preventive health services). These three elements have been described in this manner:

(1) Lifestyle - this element consists of those decisions by individuals which affect their health and over which they more or less have control. A key objective is to reduce deleterious lifestyle behaviors which create self-imposed risks, e.g., smoking, overeating, insufficient exercise, poor risk management, ineffective coping behaviors and stress management, and substance abuse.

(2) Environment - this element refers to those health matters external to the human body and over which the individual has little or no control. A key consideration is modifying and controlling the physical and psychosocial environments on behalf of better health conditions and practices.

(3) Personal Preventive Health Services refers to those health services provided to an individual by a health worker for purposes of preventing illness or conditions and maintaining health. Included are diagnostic preventive services (e.g., periodic physical exams, screening for hypertension) and intervention - oriented preventive services (e.g., immunizations, contraception, and counseling related to health behaviors).

Three work groups, one for each element, were formed and staffed by personnel from the various PHS components. Their activities involved gathering and analyzing information about each agency's prevention efforts, identifying gaps, and recommending new prevention programs. The efforts of these work groups and the subsequent departmental task forces on prevention will be documented in a comprehensive report (the Surgeon General's Report on Prevention) to be released later this year.

The Development of Mental Health Prevention Initiatives

Coincidental in time but independent of the work groups' efforts, a planning process began within ADAMHA based on a four-fold conceptual framework of prevention:

(1) Mental Health Promotion - improving well-being and fostering healthy personality development, e.g., facilitating sound parent-infant mental health.

(2) Disease Prevention - specific protection against disease and disorders, e.g., fetal alcohol syndrome.

(3) Prevention of Behavioral Consequences - preventing the harmful consequences associated with specific events or stresses, e.g., pathological emotional sequelae of bereavement, accidents resulting from driving while intoxicated, and suicide as a consequence of emotional disorder.

(4) Prevention of Behavioral Antecedents - preventing high-risk behaviors which are conditions precedent to physical, emotional, and behavioral problems, e.g., heavy teenage drinking, smoking, and experimental drug use.

This framework served as the guide for prevention program development within NIMH as well as NIAAA and NIDA. Importantly, this framework defines prevention as primary prevention; the focus is on populations which have not been diagnosed as psychiatrically impaired.

The major objective of this planning process was for each agency to identify new prevention programs (or initiatives). Within NIMH, senior staff engaged in an orderly, systematic effort to formulate such initiatives. The groundrules required that proposals be delineated in terms of specific goals, measurable objectives (both long and short-term), evaluation procedures, and resources required for program implementation. Clearly, the best features of accountability were to be utilized. Moreover, all proposed initiatives were to be based on research evidence, not conjecture and not do-goodism.

Within NIMH the planning effort, including the development of initiatives and any future implementation, was devised in terms of the establishment of programs. In this instance a program was defined as a cluster of related,

specific, commonly-shared goal-oriented activities, in distinction to disparate projects. The objective of specific problem-solving as opposed to more random efforts was to be a hallmark of any new prevention program. This approach represents a major departure in program conceptualization and use of Federal mental health funds.

Consistent with the basic imperative of primary prevention, each proposed initiative focuses on a specific problem area addressing the needs of a specific population for specific stated purposes. Each initiative also includes various strategy elements, e.g., research, services demonstration, health education and information, capacity-building in the non-Federal sector, and the means for technology transfer (i.e., informing the field about these efforts while they are proceeding).

Two other realities governed program planning: (1) financial limitations and (2) the need to select programs which could achieve stated measurable goals thereby showing the relevance and effectiveness of primary prevention approaches. Therefore, the proposed initiatives were cast as opportunities for the development of intervention models. The immediate goal would be to verify what works, to develop the models; the ultimate goal would be the delivery of services to people in need.

Within this framework, seven specific initiatives were selected as NIMH's recommended new prevention proposals. The subject areas of these new prevention initiatives include:

(1) Promoting effective coping among family members experiencing the stress of marital separation/divorce.

(2) Minimizing the deleterious effects of severe parental mental disorder on vulnerable children.

(3) Developing and extending effective mental health prevention programs to communities stricken by major natural disasters.

(4) Promoting the capacity of the American people to cope with the crisis of death in the family; preventing pathological grief reactions.

(5) Promoting parental competency; preventing postpartum disturbances.

(6) Fostering the mental health of children experiencing the stressful life event of hospitalization for a physical condition.

(7) Developing prevention/intervention programs to decrease suicidal behavior among high-risk populations.

After these initiatives were reviewed and approved at the NIMH and ADAMHA levels, these proposals were forwarded to the Assistant Secretary for Health. Subsequently, these initiatives have been discussed at the highest level within DHEW. Specific determinations will be forthcoming soon about priorities, approaches, funding, as well as directives about additional initiatives. Present indications are that highest priorities will be on those activities concerning children in families experiencing such circumstances as: marital disruption, severe parental disturbance, and a natural disaster.

An Emerging Prevention Plan

At the outset, the planning process was limited to the development of the program initiatives, rather than the formulation of a total agency prevention plan. However, the need for an NIMH prevention program was apparent. Two events served as stimuli for more comprehensive proposals: (1) the process of preparing the prevention initiatives, and (2) the efforts of the President's Commission on Mental Health,

its task panels, and the formal recommendations on prevention contained in the Commission's Report issued in late April 1978.

The proposals for development of a multi-faceted prevention program to be discussed later in this paper must be viewed within the context of the present status of prevention within NIMH. Several factors have and will continue to influence prevention planning:

(1) NIMH does not have an administrative locus for primary prevention activities.

(2) NIMH does not have a line item budget for prevention. Presently, supported prevention activities are funded from the services, training, and/or research budgets; no specific funds are earmarked for prevention activities within those budgets.

(3) To the extent that a program is defined as a series of interrelated projects characterized by common goals and objectives as well as an administrative locus, NIMH does not and has not had a prevention program.

(4) One full-time professional staff member at NIMH works in the area of primary prevention. The duties of this position deal with advocacy, program planning and development, in distinction to program operations.

To remedy these deficiencies, proposals have been developed regarding the establishment of an administrative structure, identification of its functions, and the resources required for an R&D primary prevention capacity within NIMH. For the sake of convenience in communications, a proposed NIMH administrative locus for primary prevention has been referred to as a "Center for Primary Prevention". However, at this point, the basic issue is better addressed in terms of the need for

some form of an administrative entity, e.g., if you will, a center (with a small c), rather than a Center (large C).

From my perspective, the scope of activities of such a unit would be guided by the following policy and program considerations:

(1) A focus on (a) stressful life events (stressors), life crises, and transition states, and (b) mental health promotion/competency-building.

(2) Crisis theory and developmental psychology as key conceptual bases.

(3) Utilization of varied strategies, including (a) social/institutional change, (b) multiple modes of intervention directed to individuals, groups, and communities, and (c) anticipatory guidance approaches.

(4) A public health perspective characterized by: (a) systematized social (community) action, (b) major problems effecting aggregates of population, (c) identified populations-at-risk, and (d) epidemiological approaches.

(5) Concern with all age groups, with an emphasis on children and families.

(6) Recognition of support system frameworks as major preventive mental health modalities.

(7) Programmatic concern with the mental health aspects of public health problems, e.g., maternal and child health, family planning, nutrition, chronic disability.

(8) Linking preventive interventions with epidemiological evidence.

The mission of an NIMH administrative unit for prevention would encompass the following functions:

(1) Implement and manage the programmatic initiatives in the NIMH Prevention Plan.

(2) In addition to the new initiatives, plan and support innovative prevention research, service demonstration projects, and program development activities.

(3) Plan and support an extramural national primary prevention training academy. This facility would conduct a range of primary prevention training programs and sequences for prevention specialists, other mental health workers, and related community caregivers.

(4) Plan and support extramural field stations and centers of excellence for primary prevention research. Such facilities would perform clinical trials, and pursue comprehensive, focused research programs.

(5) Conduct primary prevention program development workshops and conferences to advance the state-of-knowledge and to disseminate information to the field.

(6) Expand the present Primary Prevention Publication Series and develop an information collection, retrieval, and dissemination capacity.

(7) Develop and administer a support program of demonstration projects to the States for the establishment of State-level offices of primary prevention within departments of mental health.

(8) Serve in a coordinating capacity to facilitate program development/ analyses, linkages, and information exchanges with respect to prevention activities carried on by other operating NIMH components.

(9) Provide technical assistance on primary prevention within NIMH, ADAMHA, State departments of mental health, CMHCs, other Federal and local agencies, and relevant research, training, and service organizations and institutions.

(10) Serve in an advisory capacity to the Director, NIMH on primary prevention policy and programs.

(11) Convene and serve as the secretariat for an ongoing NIMH professional staff Prevention Advisory Group.

(12) Convene and serve as the secretariat for an ongoing advisory program development panel composed of non-Federal experts in primary prevention and related fields.

If these functions are agreed upon, additional staff will be required. A staffing pattern consistent with the above functions has been developed for agency consideration.

Prevention and the Commission's Report

The issues of prevention programming, budgeting, administrative locus, and staffing were addressed in the Report of the President's Commission on Mental Health (1978):

> At present our efforts to prevent mental illness or to promote mental health are unstructured, unfocused, and uncoordinated. They command few dollars, limited personnel, and little interest at levels where resources are sufficient to achieve results. If we are to change this state of affairs, as we believe we must, the prevention of mental illness and the promotion of mental health must become a visible part of national policy. (p. 53 - Vol. I)

The implications of this statement are monumental and challenging. Considering the significance of the source, prevention has moved over the brief period of about three years from virtually total neglect, if not derision, to a sanction, and now to a national mandate.

The Commission also recommended:

(1) The creation of a Center for Prevention with a budget of $10.M to start, and a funding level of no less than ten percent of the NIMH budget within ten years.

(2) Primary prevention be the major priority of this Center.

(3) A focus on children be "the first priority".

(4) Program activities emphasize a focus on stressful life events and populations at risk.

The Commission identified three major goals for a prevention program:

(1) preventing new cases of mental illness and severe emotional disturbance,

(2) reducing the impact of dysfunctional stresses and life crises by developing coping skills, and

(3) promoting the strengths, resources, and competencies of individuals, families and communities.

Consistent with the initial funding level recommended by the Commission, the complex PHS/DHEW budget preparation process for FY 1980 (commencing in October 1979) includes a $10.M item for prevention. However, final determinations on the departmental budget have not been set, and uncertainty prevails at present as to what the precise recommended level of funding for prevention will be in the proposed FY 1980 budget.

Shortly after the Commission Report was released, the Secretary of DHEW directed that a departmental task force be established to develop an implementation plan. The final report of this task force is to be completed by late September 1978. The recommendations of the task force with respect to prevention as well as all other parts of the Commission Report will be important determinants in the future of the entire mental health enterprise.

DISCUSSION

Clearly, the events of the past year indicate that we have arrived at a crossroads with respect to the mental health field in general, and to primary prevention's future in specific. Unprecedented opportunities may be at hand to demonstrate the effectiveness and relevance of primary prevention. The decision-making processes about program, budget, administrative locus, and staffing are taking place at high levels within DHEW, Though it appears that a commitment has been made to the concept of prevention, precisely how that commitment will be translated into resources and the nature of the mandate await completion of important debate within the bureaucracy.

Notwithstanding all the planning for prevention and all the official statements favoring prevention, the fact remains that prevention continues to evoke considerable skepticism and misunderstanding. Any lack of enthusiasm or consensus about the importance of prevention which exist at the Federal level merely mirror the prevailing views in the field. Convincing non-mental health decision-makers about the positive imperatives of prevention is exacerbated by negative attitudes among mental health workers and the absence of an organized militant constituency for prevention.

If all of the foregoing sounds terribly bureaucratic, it is! But for those of you who have a commitment to prevention, I submit that your future is inextricably interwoven with the outcome of those bureaucratic activities which concern prevention.

Over the years, many mental health workers have taken the position: "We have no time for prevention. Our patients are in pain, and our obligation, first and foremost, is to care for the psychiatric casualties." Such advocates of the status quo seem to ignore the reality that people under stress, people experiencing a crisis situation or a transition, are hurting and in need of help. I would submit that in a caring society we have an equal obligation to reduce the likelihood of severe dysfunction and needless stress as well as to promote effective coping.

Preventive efforts do not imply or suggest abandoning the mentally ill, but rather balancing that concern with the prevention of dysfunction and the promotion of mental health. The issue is not either/or, but a reordering of priorities, resources, and values.

CONCLUSION

This concluding section is prefaced by the following quotation:

> "The long fallow period in the development of a preventive orientation to mental health problems nears its end. The desparate state of mental health needs (and their ratio to manpower, current or potential) has finally forced itself upon our awareness -- and our conscience " (Cain, 1967),

These words, written by my good friend Al Cain, appeared in a paper entitled "The Perils of Prevention" published in the American Journal of Orthopsychiatry in July 1967. The message is sobering!

This paper closes, as it began, with reference to my presentation of one year ago:

> This is a time for optimism and much hope. However, (1) most mental health workers are "waiting it out", hoping that the current ascendency of primary prevention is but a fad, soon to recede, (2) all causes or movements tend to come and go as a swing of the pendulum,and (3) with little exception, the prevention message has not been sold to the American people. There is much to do.
>
> This opportunity, this moment in history, must be used to educate ourselves, our colleagues, our constituencies, our legislators, and the American public. Should we fail to do so, the moment is unlikely to appear again this generation. Responsibility for the future of primary prevention rests with all of us.

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